

Michigan Department of Community Health  
**Board of Medicine**  
P.O. Box 30192  
Lansing, Michigan 48909  
(517) 335-0918

## MEDICAL LICENSURE INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended  
This form is for information only.

**NOTE:** It is your responsibility to have all required documentation sent to the Board of Medicine. Questions regarding your application can be directed to the Michigan Board of Medicine at (517) 335-0918 four weeks after the date you sent the application. Please allow 6-8 weeks processing time. Applications submitted without the required licensing fee, applicant's signature and date will be returned. You are advised that an application for licensure **WILL NOT BE CONSIDERED UNTIL ALL REQUIRED DOCUMENTATION IS SUBMITTED.**

**APPLICANTS FOR LICENSURE BY EXAMINATION WHO ARE GRADUATES OF MEDICAL SCHOOLS LOCATED IN THE UNITED STATES, ITS TERRITORIES, THE DISTRICT OF COLUMBIA, OR THE DOMINION OF CANADA, MUST SUBMIT THE FOLLOWING:**

1. A completed application for medical license, and controlled substance license if desired, on the enclosed forms.
2. A check or money order, drawn on a U.S. financial institution, (made payable to the **STATE OF MICHIGAN**) in the amount of \$150.00 for a medical license only, or a total of \$235.00 if you are also applying for a controlled substance license. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.
3. A completed Certification of Medical Education Form (attached). The Dean or Registrar of the medical school you attended must submit this form directly to the Board.

**NOTE: All medical schools accredited by the Liaison Committee on Medical Education (LCME) are approved by the Board.**

4. Certification of your examination scores submitted directly to the board from either the Federation of State Medical Boards at (817) 868-4000, website: [www.fsmb.org](http://www.fsmb.org) or the National Board of Medical Examiners (if tested May 1994 or earlier) at (215) 590-9700, website: [www.nbme.org](http://www.nbme.org).
5. Certification of successful completion of 2 years postgraduate clinical training in an active program approved by the Board. The Director of Medical Education where you completed your postgraduate training must submit the Certification of Postgraduate Training Form (attached) directly to the Board.

**NOTE: All active, postgraduate clinical training programs accredited by the Accreditation Council of Graduate Medical Education (ACGME), the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, or the National Joint Committee on Accreditation of Pre-registration Physician Training Programs of the Canadian Medical Association are approved by the Board. All hospitals accredited by the Joint Commission on Accreditation of Hospitals (JCAH) are Board approved.**

6. If you have ever held a permanent license in another state, official verification of your license must be received in this office directly from the other state(s). You may use the Verification Form that is attached to this application. Most states charge a fee for providing license verification.

ORIGINAL LICENSES WILL EXPIRE ON JANUARY 31 OF THE FOLLOWING YEAR. SUBSEQUENT RENEWALS ARE FOR A THREE-YEAR PERIOD.

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[www.michigan.gov/healthlicense](http://www.michigan.gov/healthlicense)

## MEDICAL LICENSURE INSTRUCTIONS - FOREIGN GRADUATES

Authority: P.A. 368 of 1978, as amended  
This form is for information only.

**NOTE:** It is your responsibility to have all required documentation sent to the Board of Medicine. Questions regarding your application can be directed to the Michigan Board of Medicine at (517) 335-0918 four weeks after the date you sent the application. Please allow 6-8 weeks processing time. Applications submitted without the required licensing fee, applicant's signature and date will be returned. You are advised that an application for licensure **WILL NOT BE CONSIDERED UNTIL ALL REQUIRED DOCUMENTATION IS SUBMITTED.**

### APPLICANTS FOR LICENSURE BY EXAMINATION WHO ARE GRADUATES OF FOREIGN MEDICAL SCHOOLS MUST SUBMIT THE FOLLOWING:

1. A completed application for medical license, and controlled substance license if desired, on the enclosed forms. Please be sure to check that you are applying for license by examination and controlled substance license, as applicable.
2. A check or money order, drawn on a U.S. financial institution (made payable to the **STATE OF MICHIGAN**), in the amount of \$150.00 for a medical license only, or a total of \$235.00 if you are also applying for a controlled substance license. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.
3. A completed Certification of Medical Education for Graduates of Foreign Medical Schools form (attached). This form must be completed and returned to the Board directly from the medical school you attended.
4. Certification of your examination scores submitted directly to the Board from the Federation of State Medical Boards. You may contact that agency at (817) 868-4000, website: [www.fsmb.org](http://www.fsmb.org).
5. Certification of successful completion of 2 years postgraduate clinical training in an active program approved by the Board. The Director of Medical Education where you completed your postgraduate training must submit the Certification of Postgraduate Training Form (attached) directly to the Board.

**NOTE:** All active, postgraduate clinical training programs accredited by the Accreditation Council of Graduate Medical Education (ACGME), the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, or the National Joint Committee on Accreditation of Preregistration Physician Training Programs of the Canadian Medical Association are approved by the Board. All hospitals accredited by the Joint Commission on Accreditation of Hospitals (JCAH) are Board approved.

6. A copy of your ECFMG Certification.
7. If you have ever held a permanent license in another state, official verification of your license must be received in this office directly from the other state(s). You may use the Verification form that is attached to this application. Most states charge a fee for providing license verification.

ORIGINAL LICENSES WILL EXPIRE ON JANUARY 31 OF THE FOLLOWING YEAR. SUBSEQUENT RENEWALS ARE FOR A THREE-YEAR PERIOD.

Michigan Department of Community Health

**Board of Medicine**

P.O. Box 30192

Lansing, Michigan 48909

(517) 335-0918

**INSTRUCTIONS FOR A FULL MEDICAL LICENSE FROM  
A CLINICAL ACADEMIC LIMITED LICENSE**

Authority: P.A. 368 of 1978, as amended

This form is for information only.

**NOTE:** It is your responsibility to have all required documentation sent to the Board of Medicine. Questions regarding your application can be directed to the Michigan Board of Medicine at (517) 335-0918 four weeks after the date you sent the application. Please allow 6-8 weeks processing time. Applications submitted without the required licensing fee, applicant's signature and date will be returned.

**Section 17031 of PA 368 of 1978, as amended, states that the board may grant a full license to individuals who have held a Clinical Academic Limited License if the applicant has been engaged in the practice of medicine for not less than 10 years after completing the requirements for a degree in medicine located outside the United States or Canada by demonstrating the following:**

1. That the applicant has completed not less than 3 years of postgraduate clinical training in an institution that has an affiliation with a medical school that is listed in a directory of medical schools published by the World Health Organization (WHO).
2. That the applicant has achieved a passing score on a combination of examinations (FLEX, NBME, or USMLE) acceptable for initial licensure.
3. That the applicant has safely and competently practiced medicine under a clinical academic limited license for 1 or more academic institutions located in this state for not less than 2 years immediately preceding the date of application for a full license and that during that time the applicant functioned not less than 800 hours per year in the observation and treatment of patients.

**THE FOLLOWING MUST BE RECEIVED IN THIS OFFICE:**

1. A completed application and a check or money order, drawn on a U.S. financial institution (made payable to the **STATE OF MICHIGAN**), for the appropriate amount. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is destroyed.
2. A medical school certification form completed by your medical school and forwarded directly to this office from the medical school (unless already on file with this office).
3. Certification of successful completion of three years postgraduate clinical training in an active, Board approved program in a Board approved hospital or institution. The Certification of Postgraduate Training form (attached) must be submitted directly to the Board by the Director of Medical Education where you completed your postgraduate training.
4. A transcript of the acceptable combination of licensure examinations (FLEX, NBME and/or USMLE) received in this office directly from the examining agency.
5. The Certification of Practice in an Academic Institution form (attached) must be submitted directly to the Board by the Director(s) of Medical Education where you practiced under the Clinical Academic license. You must have practiced under a clinical academic license for at least 2 years in order to qualify for full licensure.

**Board of Medicine**

P.O. Box 30192

Lansing, MI 48909

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www.michigan.gov/healthlicense

**APPLICATION FOR MEDICAL DOCTOR LICENSURE**

Authority: Public Act 368 of 1978, as amended.

If this form is not completed, a license will not be issued

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard Street, Detroit, MI 48226 (Telephone 1-800-882-9539).

**Board Use Only**

License Number

Date of Licensure

**Type or Print Only****I AM APPLYING FOR THE FOLLOWING:**
☐ **License by Examination Fee: \$150.00 71-4301-01**

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Daytime Phone Number
Street Address		
City	State	ZIP Code
All Previous Names and/or Birth Name Used (if applicable)		
Have you ever held a health professional license in Michigan?		Michigan Permanent I.D. Number and Expiration Date
<input type="checkbox"/> Yes <input type="checkbox"/> No		

**Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.**

1. Have you ever been convicted of a felony?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum of 2 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you been treated for substance abuse in the past 2 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Have you ever had a federal or state health professional or controlled substance license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Have you ever been denied the privilege of taking an examination by any state medical board?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

9. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privilege involuntarily modified? ☐ Yes ☐ No

10. Do you hold or have you ever held a permanent medical license in any state, U.S. Territory or Canadian Province? If yes, list the state(s) U.S. Territory or Province in which you hold or have held a medicine license, the license or registration number, the date issued, and how the license was obtained. DO NOT LIST TEMPORARY LICENSES. **You must have each licensing agency verify licensure directly to this board office. (Attach additional sheets, if necessary)** ☐ Yes ☐ No

State, U.S. Territory or Province	License Number	Date of Issue	How obtained (Endorsement or examination)

**Provide a complete chronological record of your educational preparation.**  
Attach additional sheets if necessary.

Name and Address of Institution	Dates of Attendance From To		Degree

**Provide a description of your professional medical experience.**  
Attach additional sheets if necessary.

Name and Address of Employer	Dates of Practice From To		Duties

### CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant

Date

Michigan Department of Community Health  
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**CERTIFICATION OF MEDICAL EDUCATION FOR GRADUATES OF MEDICAL SCHOOLS  
LOCATED IN THE UNITED STATES, ITS TERRITORIES, THE DISTRICT OF COLUMBIA, OR  
THE DOMINION OF CANADA**

Authority: Public Act 368 of 1978, as amended  
If this form is not completed, a license will not be issued.

**INSTRUCTIONS TO APPLICANT:**

Complete Section I. Type or print your name exactly as it appears on your application. For Section II, send this form to be completed by the Dean of the medical school you attended. This certification must be submitted directly to the Michigan Board of Medicine by the medical school.

**SECTION I - APPLICANT INFORMATION**

First Name	Middle Name	Last Name
Social Security Number	Date of Birth	Daytime Telephone Number
Street Address		
City	State	ZIP Code
All Previous Names and/or Birth Name Used (if applicable)		
Date of Admission	Date of Graduation	

Signature of Applicant	Date
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**APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DEAN OF  
YOUR MEDICAL SCHOOL FOR COMPLETION OF SECTION II.**

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

**TO BE COMPLETED BY THE DEAN OR REGISTRAR OF THE MEDICAL SCHOOL**

**INSTRUCTIONS FOR COMPLETING SECTION II:**

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

**SECTION II - CERTIFICATION OF MEDICAL EDUCATION**

Name of Medical School

Street Address of Medical School

City, State and ZIP Code

I certify that \_\_\_\_\_ attended the  
(Applicant's Name)

medical school named above from \_\_\_\_\_ to \_\_\_\_\_  
(Month/Day/Year) (Month/Day/Year)

and was/will be granted the degree of \_\_\_\_\_ on

\_\_\_\_\_  
(Month/Day/Year)

\_\_\_\_\_  
Signature of Dean or Registrar

\_\_\_\_\_  
Date of Signature

**(S E A L)**

\_\_\_\_\_  
Print or Type Name of Dean or Registrar

If school has no seal, please indicate

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**CERTIFICATION OF POSTGRADUATE TRAINING**

Authority: Public Act 368 of 1978, as amended  
If this form is not completed, a license will not be issued.

**INSTRUCTIONS TO APPLICANT:**

Complete Section I. Type or print your name exactly as it appears on your application. For completion of Section II, send this form to the Director of Medical Education where you completed your postgraduate training. This certification must be submitted directly to the Michigan Board of Medicine by the Director of Medical Education.

**SECTION I - APPLICANT INFORMATION**

First Name	Middle Name	Last Name
Social Security Number	Date of Birth	
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	

Signature of Applicant	Date
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**APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DIRECTOR OF MEDICAL EDUCATION FOR COMPLETION OF SECTION II.**

Name

## TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION

### INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

### SECTION II - CERTIFICATION OF POSTGRADUATE TRAINING

Name of Hospital	
Street Address of Hospital	
City, State and ZIP Code	
<p>I certify that _____ a graduate of the  <div style="text-align: center;">(Applicant's Name)</div>         _____ medical school, has successfully completed postgraduate          clinical training offered by the hospital named above from _____, to _____,  <div style="text-align: center;">(Month/Day/Year) (Month/Day/Year)</div>         in the clinical area of _____.</p> <p>Is this an active training program accredited by the ACGME, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, or by the National Joint Committee on Accreditation of Preregistration Physician Training Programs of the Canadian Medical Association? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 45%;"> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <div style="text-align: center;">Signature of Director of Medical Education</div> </div> <div style="width: 45%;"> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <div style="text-align: center;">Date of Signature</div> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 45%;"> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <div style="text-align: center;">Print or Type Name of Director of Medical Education</div> </div> <div style="width: 45%; text-align: center;"> <p><b>(SEAL)</b></p> <p>If hospital has no seal, please indicate</p> </div> </div>	
<p><b>NOTE: Certification of Postgraduate Training will not be accepted if signed and submitted more than 15 days prior to actual completion.</b></p>	

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**CERTIFICATION OF PRACTICE IN AN ACADEMIC INSTITUTION**

Authority: Public Act 368 of 1978, as amended  
If this form is not completed, a license will not be issued.

**\* DO NOT COMPLETE THIS FORM UNLESS YOU HAVE HELD A CLINICAL ACADEMIC LICENSE \***

**INSTRUCTIONS TO APPLICANT:**

Complete Section I. Type or print your name exactly as it appears on your application. For Section II, send this form to be completed by your chief academic officer where you practiced under a **clinical academic limited license**. This certification must be submitted directly to the Michigan Board of Medicine by your Director of Medical Education.

**SECTION I - APPLICANT INFORMATION**

First Name	Middle Name	Last Name
Social Security Number	Date of Birth	
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	

Signature of Applicant	Date
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**APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO YOUR DIRECTOR OF MEDICAL EDUCATION WHERE YOU PRACTICED FOR COMPLETION OF SECTION II.**

Name**TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION****INSTRUCTIONS FOR COMPLETING SECTION II:**

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

**SECTION II - CERTIFICATION OF PRACTICE IN AN ACADEMIC INSTITUTION**Name of InstitutionStreet Address of InstitutionCity, State and ZIP Code

I certify that \_\_\_\_\_ practiced medicine under a clinical  
(Applicant's Name)

academic limited license at the above institution in the clinical area of \_\_\_\_\_

from \_\_\_\_\_ to \_\_\_\_\_ and has functioned in the observation and treatment of  
(Month/Day/Year) (Month/Day/Year)

patients for not less than 800 hours per year and in so doing practiced medicine safely and competently.

I further certify that the above-named academic institution meets all of the following requirements:

- A. Was the sole sponsor or a co-sponsor, with either a medical school approved by the Michigan Board of Medicine or a hospital owned by the federal government and directly operated by the United States Department of Veterans' Affairs, of not less than 4 residency programs accredited by the Accreditation Council for Graduate Medical Education for not less than the 3 years immediately preceding the date of my signature below.
- B. Has spent not less than \$2,000,000 for medical education during each of the 3 years immediately preceding the date of my signature below. (As used in this statement, "medical education" means the education of physicians and candidates for degrees or licenses to become physicians, including physician staff, residents, interns and medical students).

Signature of Director of Medical EducationDate of SignaturePrint or Type Name of Director of Medical Education**(S E A L)**

If institution has no seal, please indicate

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**CERTIFICATION OF MEDICAL EDUCATION FOR  
FOREIGN MEDICAL SCHOOL GRADUATES**

Authority: Public Act 368 of 1978, as amended  
If this form is not completed, a license will not be issued.

**INSTRUCTIONS TO APPLICANT:**

Complete Section I. Type or print your name exactly as it appears on your application. For completion of Section II, send this form to the Dean of the medical school you attended. This certification must be submitted directly to the Michigan Board of Medicine by the medical school.

**SECTION I - APPLICANT INFORMATION**

First Name	Middle Name	Last Name
Social Security Number	Date of Birth	
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	
Date of Admission		Date of Graduation

Signature of Applicant	Date
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**APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DEAN OF YOUR MEDICAL SCHOOL FOR COMPLETION OF SECTION II.**

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

**TO BE COMPLETED BY THE DEAN OR REGISTRAR OF THE MEDICAL SCHOOL****INSTRUCTIONS FOR COMPLETING SECTION II:**

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

**SECTION II - CERTIFICATION OF MEDICAL EDUCATION**

Name of Medical School

Street Address of Medical School

City, State and ZIP Code

I certify that \_\_\_\_\_ attended the  
(Applicant's Name)

medical school named above from \_\_\_\_\_ to \_\_\_\_\_  
(Month/Day/Year) (Month/Day/Year)

and was granted the degree of \_\_\_\_\_ on  
\_\_\_\_\_  
(Month/Day/Year)

I also certify that the medical education program from which the applicant graduated was not less than 130 weeks and does not award credit for any courses taken by correspondence. I further certify that this medical education program included basic science courses in anatomy; physiology; biochemistry; microbiology; pathology; pharmacology and therapeutics; preventive medicine; and clinical sciences and clerkships completed at the hospitals or institutions listed below.

**Clinical Sciences****Name and Address of Hospital****Teaching Hospital**

Internal Medicine

☐ Yes ☐ No

General Surgery

☐ Yes ☐ No

Pediatrics

☐ Yes ☐ No

Obstetrics and Gynecology

☐ Yes ☐ No

Psychiatry

☐ Yes ☐ No\_\_\_\_\_  
Signature of Dean or Registrar\_\_\_\_\_  
Date of Signature\_\_\_\_\_  
Print or Type Name of Dean or Registrar**(S E A L)**

If school has no seal, please indicate

\* Teaching hospital means that the hospital or institution offers a postgraduate clinical training program in the same content area of the clerkship.

## CONTROLLED SUBSTANCE LICENSE APPLICATION

Authority: Public Act 368 of 1978, as amended  
If this form is not completed, a license will not be issued.

A controlled substance license is required for every person who manufactures, distributes, prescribes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended.

A separate controlled substance license is required for each business location from which you manufacture, distribute, or dispense controlled substances. If you only prescribe controlled substances at more than one location, you only need one controlled substance license.

Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration 431 Howard Street, Detroit, Michigan 48226 (telephone: 800-882-9539). The Michigan Board of Pharmacy is unable to answer questions about the federal licensing process.

<b>Board Use Only</b>
License Number
Date of Licensure

### Type or Print Only

#### INSTRUCTIONS

- CONTROLLED SUBSTANCE FEE: Initial (first time) professional license or relicensure of your professional license - \$85.00.**  
**If you already hold a professional license and your professional license expires in:**  
0-12 months the fee is \$85.00 (13757)      13-24 months the fee is \$160.00 (23757)      25-36 months the fee is \$235.00 (33757)
- M.D./D.O. Applicants: This application may not be used for physician methadone programs. Please request an application for the Physician Methadone Program.**
- Allow up to six weeks for your paper license to arrive.**

Your check or money order drawn on a U.S financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application.  
**DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name
Street		Telephone Number
City	State	ZIP Code

#### TYPE OF PROFESSIONAL LICENSE

(Please Check One):

- |  | Regular                  | or | Educational Limited      |
|--|--------------------------|----|--------------------------|
| <input type="checkbox"/> 29 - 01 D.D.S. 71-5315            | <input type="checkbox"/> | or | <input type="checkbox"/> |
| <input type="checkbox"/> 59 - 01 D.P.M. 71-5315            | <input type="checkbox"/> | or | <input type="checkbox"/> |
| <input type="checkbox"/> 69 - 01 D.V.M. 71-5315            | <input type="checkbox"/> | or | <input type="checkbox"/> |
| <input type="checkbox"/> 43 - 01 M.D. 71-5315              | <input type="checkbox"/> | or | <input type="checkbox"/> |
| <input type="checkbox"/> 51 - 01 D.O. 71-5315              | <input type="checkbox"/> | or | <input type="checkbox"/> |
| <input type="checkbox"/> 49 - 01 O.D. 71-5330              | <input type="checkbox"/> |    |                          |
| <input type="checkbox"/> 53 - 01 Pharmacy Store 71-5301    | <input type="checkbox"/> |    |                          |
| <input type="checkbox"/> 53 - 02 R.Ph. 71-5302             | <input type="checkbox"/> |    |                          |
| <input type="checkbox"/> 53 - 06 Manuf./Wholesaler 71-5306 | <input type="checkbox"/> |    |                          |

#### STATUS:

- Have you ever had any health professional license limited, suspended, revoked, denied, or surrendered?**  
☐ Yes      ☐ No  
If Yes, please explain on separate sheet.
- Is your current professional license limited as a result of Board disciplinary action?**  
☐ Yes      ☐ No

Michigan Permanent I.D. Number (as shown on your pocket card)

Expiration Date of License

Social Security Number

**I am applying for a controlled substance license in Michigan and certify that the statements and information above are true.**

Signature	Date
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The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the American's with Disabilities Act, you may make your needs known to this agency.

**Michigan Department of Community Health**  
**Bureau of Health Professions**  
P.O. Box 30670  
Lansing, MI 48909  
[www.michigan.gov/healthlicense](http://www.michigan.gov/healthlicense)

## VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

**PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.**

<b>Check the profession for which you are requesting verification.</b>		
<input type="checkbox"/> Audiology <input type="checkbox"/> Chiropractic <input type="checkbox"/> Counseling <input type="checkbox"/> Dentistry <input type="checkbox"/> Marriage & Family Therapy	<input type="checkbox"/> Medicine <input type="checkbox"/> Nursing <input type="checkbox"/> Nursing Home Adm. <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Optometry	<input type="checkbox"/> Osteopathy <input type="checkbox"/> Pharmacy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Physician's Assistants <input type="checkbox"/> Podiatry
<input type="checkbox"/> Psychology <input type="checkbox"/> Respiratory Therapy <input type="checkbox"/> Sanitarians <input type="checkbox"/> Social Work <input type="checkbox"/> Veterinary		
First Name	Middle Name	Last Name
Previous Names Used	Date of Birth	U. S. Social Security Number
State Board	License Number	Date of Issue

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State.  
Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

**PART II: To be completed by the State Licensing Board.**

Type of License:	Original Issue Date	Expiration Date
Basis for Issuance of License:		
<input type="checkbox"/> Examination - Please indicate type of exam (National, Regional, State, etc.) _____		
<input type="checkbox"/> Endorsement - Please indicate name of state _____		
License Status	Has the applicant incurred any formal or informal actions in your State?	
<input type="checkbox"/> Current <input type="checkbox"/> Lapsed <input type="checkbox"/> Inactive	<input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, Please attach certified copies of any actions.	
Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	

### CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Type or Print Name

( S E A L )

\_\_\_\_\_  
Title

\_\_\_\_\_  
Full Name of Licensing Board